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A RESEARCH DEMONSTRATION TO ASSESS THE EFFECTIVENESS OF A SPECIAL LIVING UNIT WITHIN A UNIVERSITY DORMITORY SETTING FOR THE REHABILITATION OF STUDENTS DISABLED BY EMOTIONAL DISTURBANCE.

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USE OF A RESIDENCE HALL AS A THERAPEUTIC MILIEU FOR DISTURBED COLLEGE STUDENTS IS DESCRIBED IN THIS REPORT OF A RESEARCH AND DEMONSTRATION STUDY. THE EXPERIMENTAL GROUP CONSISTED OF TEN DISTURBED STUDENTS, AND A CONTROL GROUP WAS COMPOSED OF 10 VOLUNTEER STUDENTS. ALL STUDENTS PARTICIPATED IN THE REGULAR RESIDENCE HALL PROGRAMS (ORGANIZATIONAL SPORTS, ACTIVITIES) AND SMALL GROUP MEETINGS AMONG THEMSELVES TO DEAL WITH PROBLEMS OF DEVIANT BEHAVIOR. THE EXPERIMENTAL SUBJECTS HAD REGULAR COUNSELING APPOINTMENTS, BUT THE VOLUNTEERS OBTAINED COUNSELING SERVICES ONLY AT THEIR OWN REQUEST. ADDITIONAL STAFF FOR THE RESIDENCE HALL WERE A PART-TIME UNIT LIVING DIRECTOR, A PARTICIPANT OBSERVER, AND TWO ON-CALL PSYCHOLOGISTS. SOCIOMETRIC DATA THAT WAS GATHERED SHOWED NUMEROUS MUTUAL FRIENDSHIPS AMONG CLIENTS AND VOLUNTEERS. OF FIVE SOURCES OF HELP (INFORMAL CONTACTS WITH PROJECT MEMBERS, AD HOC GROUP MEETINGS, REGULAR GROUP MEETINGS, REGULAR COUNSELING APPOINTMENTS, AND CONSULTATION WITH THE PROJECT STAFF), BOTH GROUPS RANKED INFORMAL CONTACT WITH PROJECT MEMBERS AS MOST BENEFICIAL TO THEM. GRADES OF VOLUNTEERS AND CLIENTS WERE APPROXIMATELY THE SAME. LESS USE WAS MADE OF BRIEF HOSPITALIZATION AND CHEMOTHERAPY FOR THE STUDENTS WHILE IN THE UNIT. THE PHYSICAL SETTING AND STAFF ARE DESCRIBED. A REFERENCE LIST OF 10 ITEMS IS INCLUDED. (RS)

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A RESEARCH DEMONSTRATION TO ASSESS THE EFFECTIVENESS OF A SPECIAL LIVING UNIT WITHIN A UNIVERSITY DORMITORY SETTING FOR THE REHABILITATION OF STUDENTS DISABLED BY EMOTIONAL DISTURBANCE[1, 2]

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The counselor, working in conjunction with other professional staff in a university setting, is often faced with participating in important life decisions with and on behalf of students who have severe emotional disturbances. In helping this problem group we faced the perplexing question: "Are the typical resources (counseling or psychotherapy, chemotherapy, brief in-patient care in a Student Health Service) sufficient to maintain these students functioning in college?" What alternatives are there when professional staff are doubtful whether the student can be effectively helped with the resources available on campus?

One choice that most counselors have tried is "taking their chances" in working as part of a loosely organized team to help the potentially suicidal, the borderline schizophrenic, and the severe neurotic. While this course of action can lead to legitimate worrying and apprehension on the part of the staff involved, the other alternatives also contain costly risks for the student.

The "send-them-home" therapeutic approach is often a poor choice for a number of reasons. Uprooting the student from the university community is in itself a disruptive experience. Then, too, for the late

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1 In preparing this paper I have drawn heavily on source material prepared by other members of our project staff: Eugene Wiesner, Walter S. Friesen, Leon Rappoport and Danielle Haygood.

2 Presented at the 1966 meetings of the Association of Rehabilitation Centers.

adolescent, parents may be more a source of conflict than a source of support. Moreover, many of our students--as in most other land-grant colleges--have their homes in small towns or rural areas with less adequate rehabilitation facilities than those provided on the campus.

The alternative of in-patient hospital treatment involves the likelihood of the student's seeing himself as incompetent, as sick and unable to cope with his problems. Remaining in college appears to be a last source of positive self-regard for some students.

In terms of the effects on vocational preparation, psychiatric hospitalization or a return home may at best prolong the client's education, thereby reducing his productive years or lead to his being employed at a level either below his capacities or incompatible with his interests. We know, too, that some members of this group can continue to produce scholastic work of very high quality even when undergoing great despair. For example, a psychologist was working with a student who was severely depressed and showed some disorganization in his thinking. He had made one serious suicidal attempt and continued to be preoccupied with ideas of suicide. The faculty member who referred him recognized that he needed help but added "I sure hope you can help him--he's the best student I have ever had."

One other consideration should be raised: professionals experienced in working with the late adolescent age group are familiar with the instability of diagnosis and presenting symptoms and with the uncertainty of prognostic judgments for these clients. Severe distress and disorganization which are transient, and dramatic responses to treatment are not uncommon. Intervention is clearly needed, but transitory crises should not require a major interruption of the educational program.

THE INCIDENCE OF EMOTIONAL DISABILITY AMONG OUR STUDENTS

What is the incidence of psychological disturbance among college students? Baker (1965) in his review of the literature finds ten per cent is a common figure. For those students seen in a counseling setting such as ours, twenty per cent is a representative figure. How many students might need a specialized intensive service such as we propose? In response to this query, our staff has nominated approximately about five per cent of our caseload for the last three academic years; this represents fifty to sixty students per year out of a total caseload of about 1100 students per year.

A follow-up of these nominees has shown that in spite of both average academic aptitude and average achievement, the incidence of drop-outs has been fifty per cent per year. This attrition rate compares very unfavorably with that of students in general for whom the attrition rate is forty-eight per cent over four years.

A previous local study of students-in-general by Hoyt and Danskin (1962) found that the number of students actually dismissed for low grades was small: seventeen and one-half per cent. Moreover, the grade-point averages of these drop-outs were not remarkably low: forty-eight per cent had a C- average or higher and, at that time, if maintained, their level of performance would have been sufficient for graduation. Personal problems and vocational uncertainty ranked high among reasons indicated for leaving the university, and certainly some of the difficulties in study and poor motivation so frequently reported by these students are a product of emotional disturbance. Complaints such as these are typical presenting problems among those with disabilities from emotional causes.

THE EVOLUTION OF OUR EXPERIMENTAL LIVING UNIT

In attempting to cope with the problems repeatedly confronting us in providing assistance to the emotionally disturbed student, our Counseling Center staff began searching for solutions other than those traditionally offered (Sinnett, et al, 1966). As we contemplated various innovative approaches, we became intrigued with the possibility of adapting the halfway house model as a rehabilitation service. Our conception was that of a preventive halfway house as described by Huseth (1961) rather than that of restoring a person from an institution to society. By means of a VRA planning grant we were enabled to visit selected halfway houses. The two programs which had the most influence on us were Wellmet House (Bennett, 1965) and Woodley House (Doniger, Rothwell, and Cohen, 1963). A conference was held to assist us in adapting the halfway house approach to use in a university setting as well as to plan follow-up research and a study of the social-psychological aspects of the rehabilitation processes in a living unit.

In response to recommendations by our consultants we visited two therapeutic community programs described in Glasscote, et al, 1964: Prairie View Hospital and Fort Logan Mental Health Center. These visits stimulated us to refine our planning to incorporate the therapeutic community approach. In the final stages of our planning, the granting agency requested us to establish our living unit in an existing university residence hall rather than to operate as an autonomous unit off campus. A visit to the Nebraska Psychiatric Institute's boarding house program gave us some helpful ideas in implementing this request.

We decided to use selected volunteers as an integral part of our rehabilitation program. We felt that they might serve as role models for the disturbed and that they could respond to deviate behavior in ways other than rejection, hostility, anxiety and withdrawal of interest. Deviate behavior, we have found, although pardonable initially, often pulls these affects if sustained. This kind of feedback obviously undermines further the self-esteem of the distressed student.

Our initial pool of volunteers was not large: we chose four men out of eleven volunteers from the residence hall where we were to be located. This source was partly dictated by the dormitory's residents' desire not to be displaced. We didn't want the project members to be the target of hostility because of the intrusion of our unit into the residence hall. Female volunteers were chosen from nominations by counselors as well as nominations by the Assistant Dean of Women.

In February, 1966, we began with our first group of students. The disturbed students were selected from a pool of over thirty-two clients nominated by counselors and our consulting psychiatrist. Some potential clients dropped out of school before the unit opened and some refused the recommendation so that all remaining eligible candidates who wanted the service were accepted. Four male and five female clients were in the unit the spring term. Each was studied intensively. The diagnostic composition of the client group and the control group may be seen in Table 1.

Table 1

Diagnostic Composition of the
Experimental and Control Groups

	E	%	C	%
Schizophrenic or schizoid	4	44.5	6	40.0
Neurotic	3	33.3	6	40.0
Personality trait disturbance	2	22.1	2	13.3
Adjustment reaction of adolescence	0	0.0	1	6.7
	9	99.9	15	100.0

The physical setting of the unit was the first floor of a small, older university residence hall close to the main campus. Two apartments for men and two for women were used. The first floor was used because both sets of apartments and the main entrance were all adjacent to the common lounge. The dormitory director's office was situated near the female quarters so that supervision was adequate. The capacity of the unit was ten males and ten females. Half of each of these groups were clients and half were volunteers. Meals were taken in the dining hall with the other forty students living in the hall.

The experimental living unit students participated fully in the residence hall programs, attending meetings, holding office, serving on committees, and participating in the hall intramural sports and social activities. The project itself soon came to be popularly called "The Waltheim Project" after the name of the residence hall.

But how is a therapeutic community or milieu created within a university residence hall? We reasoned that the central aspect of our treatment program was to be the intimate daily interaction among the residents, that the students themselves would be the principal source of help. As noted above, ecological features of the setting facilitated

interaction. We chose not to impose pre-planned rules and structures, on the assumption that the task of developing cooperative problem-solving relationships is basic to the establishing of a therapeutic community. From having observed the operation of Wellmet House we felt that normal student volunteers might be one of our chief agents of change. However, we have chosen to minimize the differences between the helped and the helping, assuming that all members of the therapeutic community both give and receive. The differences in some instances were so minimal that even our neutral observers and some project staff misidentified helped and helper. Another important difference between our program and that of Wellmet is that our clients and volunteers were currently enrolled as students and were peers in age and socio-economic status while at Wellmet there were marked differences between students and clients in age, intellectual level, and socio-economic status. Our clients were also less severely disturbed than those typically resident in a halfway house because our clients had to be sufficiently integrated to continue as students.

Additional staff were provided for the living unit above the normal coverage furnished by the university for the residence hall: a part-time female assistant residence hall director and a male graduate student in Sociology who lived in the men's quarters as a participant observer. We anticipated, correctly, that there would be crises similar to those reported in the literature on residential treatment (e. g. Redl and Wineman, 1961), and we felt responsible to provide personnel to cope therapeutically with such critical events. Two of the project staff, one a clinical psychologist and the other a counseling psychologist,

were available to assist in intervention. We have come to feel that some of the small spontaneous group meetings which we named ad hoc groups, oriented around a current, intense problem, were very beneficial. For example:

> Teresa's cousin, Angela, phoned me saying that Teresa had come to her apartment crying and very upset. It was evident that Angela herself felt frightened and concerned about what Teresa might do. I asked if Angela could bring Teresa to my home. Teresa was crying profusely and showing diffuse anxiety. If she had not resided in the living unit my efforts would have been oriented toward support and preparing her and making arrangements for hospitalization at Student Health.
>
> She complained bitterly that no one in the unit would talk to her or listen to her to alleviate her distress. I asked if she would return to the unit to talk about this with her roommates. The meeting revealed that others felt that Teresa was communicating that she wanted to be left alone. Both Teresa and her roommates reflected about their contribution to the problem (misreading of cues, not communicating distress signals) and I felt this process opened the way for Teresa to be better able to find help for herself from her peer group. If she had lived in an ordinary dormitory, I would not have attempted to use the group in this manner.

In addition to extra personnel, to the use of normal volunteers, and to the spontaneous ad hoc group meetings, regular weekly group meetings of the experimental unit as a whole were held. These meetings, oriented primarily toward problems in group living, have been important in establishing the unit as a therapeutic community.

While every client in the unit had regular continuing counseling appointments in the university's Counseling Center, counseling services to the volunteers were available at the student's own request. Two of the project research staff alternated in providing one hour per day in

consultation to the entire unit in an office in the residence hall. Their time was used by the residence hall staff, by volunteers, or by clients. It should be emphasized that the living unit was used as an additional rehabilitation resource rather than as a substitute for conventional services. Medical and psychiatric consultation were available to staff and students as part of the project in addition to the routine services available to all university students.

DOES THE LIVING UNIT WORK? SOME PRELIMINARY FINDINGS AND IMPRESSIONS

Of our nine clients in our initial group, seven have returned to the university this fall, one has graduated, and one has transferred to a junior college. Also their grades were approximately the same as those obtained by the volunteers. Only two of our original clients have returned to our unit this second semester of our operation. The remainder of those who have returned are living elsewhere in university or off-campus housing.

Some of the preliminary research findings offer support that we were indeed successful in establishing a therapeutic community. Clients were asked to rank the five sources of help furnished them: (1) informal contacts with project members, (2) the ad hoc group meetings, (3) regular group meetings, (4) regular counseling appointments, and (5) consultation with project staff. All ranked the informal contacts with project members as most helpful. Volunteers (who did not have regular counseling appointments) ranked the remaining four sources of help in an order much the same as that obtained for the clients. Even for such a small number of subjects our findings are statistically significant: both

volunteers and clients feel that their informal contacts with project members were the greatest source of help to them. The rankings of four sources of help for both groups yielded a W of .57 (N=18; $p < .001$).

Characteristically therapeutic community and other programs emphasizing the social milieu have not systematically studied social behavior. We feel that this is essential in order to establish whether we have in fact established a therapeutic milieu and in order to understand the helping process. Toward this end we have invested considerable effort in the development of suitable instruments.

Sociometric data gathered from all residents of the unit concerning their choices of friends and of helpers in the unit indicate the establishment of a therapeutic community. The volunteers were most heavily chosen as helpers by the clients, yet volunteers named their helpers from among clients and volunteers with nearly equal frequency. We did not find "doctor-patient type" relationships nor did we find that friendship choices separated the group into cliques of the helpers and the helped. Although volunteers were generally more popular, there were numerous mutual friendship choices among clients and volunteers.

Seating patterns in the dining room are congruent with sociometric results. Project members who sat together with greater-than-chance frequencies generally included those who listed each other as friends on the sociometric instrument. Most of the cases in which friendship choices were not observed together are explainable by variations in their academic schedules. Further evidence of group development is provided by the finding that, as compared with the first half of the semester, in the second half there is a significant increase in the

number of group members sitting together. And these seating patterns again cut across the client-volunteer dimension.

A comprehensive record was obtained covering each project member's activity on four different days of the semester. These data were organized so as to permit comparisons between clients and volunteers on three variables: amount of time spent in conversation, amount of time spent alone, and number of contacts with other persons. Conversation time is quite stable for both clients and volunteers; all spend about 25% of their days in conversation, although this proportion increases slightly on weekends. Clients, however, consistently spend more time alone and have fewer contacts than volunteers. Because this difference is greatest on weekends, it appears that clients may suffer certain therapeutic losses during periods when they must rely more heavily on their own resources. This view is supported by comparisons with a clinical control group (students in counseling who are not project members). Time alone is greater, and contacts fewer, for controls than for clients. Thus, it is evident that the living unit "pulls" the clients into social interaction.

The nature of the helping relationship between volunteers and clients appears to be on an egalitarian, peer basis. It was by no means limited to reassurance and support. Members were encouraged to be open and honest with one another and to deal with deviate behavior by confrontation rather than by rejection, anxiety, and hostility. Some of the disturbed students also needed a kind of monitoring and supervision: irregular eating, sleeping, excessive drinking, and erratic attendance at class were noted and dealt with by the group as problems to be handled by the community.

As one might anticipate, the volunteers themselves had feelings of anger, anxiety, and inadequacy to cope with as a result of interacting with disturbed peers. Many of them felt they gained insight and self-understanding as a result of being in the project. Consultation with staff as well as the regular group meetings were used to help them; and, as indicated above, they turned to one another and the clients as resource persons. To some extent our experiences with volunteers have been similar to those reported in the literature on T-groups (Bradford, Gibb, and Benne, 1964).

It seems that we made less use of brief hospitalization and chemotherapy for the clients in the unit when compared with their previous use of these services. Counselors have come to view the unit as an additional resource. It is our impression that the counseling interviews with the unit residents are more intense than with clients not in the unit. Project members seem much more concerned with current interpersonal relations than they are with memories, past events, and fantasies. Some schizoid clients feel threatened by the intense interaction; yet it seems that they make progress in establishing and maintaining social relationships. The coed living situation has created opportunities that might not otherwise exist for casual relationships among the sexes. This condition facilitates mature social behavior and has favorably affected the conduct of the total residence hall population.

A brief vignette of one of the clients may illustrate the use of the unit:

> Although Terry had few close friends, he showed no clinically obvious personality disturbance until his senior year at a prominent university. At that time, he developed

a crippling concern with perfection in his work which ultimately led to a cessation of study. Concomitantly, he began to show severe, diffuse anxiety, and preoccupation with suicide. He left school and received four months' inpatient psychiatric treatment.

While living at home he enrolled as a part-time student at Kansas State University. He lived a life of relative social isolation and felt quite estranged from his family. Intense feelings of ambivalence and conflict over being dependent on his family, as well as his difficulty in establishing meaningful relationships with peers, led to his counselor recommending he enter the rehabilitation living unit.

The student found considerable acceptance among the members of the living unit. He showed charm, wit, sophistication, and leadership. However, he lived in fear that his colleagues would discover his "evil" inner life and his inadequacies--he felt that he deceived others by his appearance. When the living unit closed in the spring, he was visibly upset at the loss of easy companionship and showed some return of moderate anxiety. He resumed taking thorazine for a short while. He has returned to the unit this fall. It is our hope that he can come to see others interest in him as genuine and that this will foster greater self-acceptance. The student received straight A's in all of his completed course work, but he is still threatened by committing himself to definite career plans. Although popular enough to have been elected corridor president, he is threatened at the prospect of making friends outside the group and recognizes he is quite dependent on it. Ultimately, we hope that he can generalize the social adjustment he has made within the unit.

Support provided by the state rehabilitation program, and part-time employment secured by him have enabled him to be financially independent while he is earning his degree, which will be conferred next June. He is considering enrolling in graduate school on completion of his BA degree.

This year some of the smaller, less economical living units at Kansas State University have been closed and the university has provided us with accomodations in a 600 person high-rise dormitory. Both project staff and students returning to the project (volunteers as well

as clients) were quite distressed about the impact of this move on the project. The architecture of this dormitory, as is true of many such structures, could be conducive to isolation or a deterrent to the formation of a cohesive group. The staff was apprehensive about being able to create a therapeutic milieu and greatly concerned about the need for modifying our instruments for observing social interaction. We shared our concerns quite openly with the student group and they have appeared to form a cohesive group in spite of the difficulties to surmount in the new setting. Having had a cadre of students to assist us was a definite asset. Our findings will probably be more generalizable in the new setting since it is more typical in construction than our previous setting.

CLOSING REMARKS

We feel that our experimental living unit shows much promise as a rehabilitation service. As we add additional cases in future years of operation we shall have a firmer basis for making such a judgment. We hope to prevent drop-outs, and to help our disturbed students to actualize their potential. Formal follow-up studies are already underway comparing the clients with matched control subjects who receive conventional services only. In this manner we should be able to evaluate whether the living unit is an effective addition to methods currently used in the rehabilitation of the emotionally disturbed college student.

Finally, a note about the acceptance of the project. Within the profession of mental health workers in the state there has been much interest in and acceptance of the project. Also, the university

administration and staff have been understanding and supportive of the project in spite of some rather major adjustments required by this advent of co-educational living. Indeed, the one major problem within the administration centered not in the rehabilitation project itself but in the reconciling of the two rather different sets of rules and regulations governing men and women. Interestingly enough, the only adverse publicity given to the project was concerned entirely with the co-educational aspects of the living unit and appeared to be precipitated by an obviously well-intentioned news story written by a journalism student for the university's Collegian. A number of papers in Kansas editorialized about the dangers of coed living.

After one semester the project seems to be quietly accepted by students. An interesting and extremely valuable side-effect of the planning for the project and its initial operation has been the solidifying of the campus' diverse mental health resources and considerable self-evaluation within the various student personnel services of the university. Communication with the faculty and university administration about the project has been facilitated by luncheons held at the residence hall and informal conversation with project staff and students in the unit. While it is too early to be sure, there is evidence that both faculty and administration regard the project not as a cloister for the maladjusted who ought not to be allowed on campus, but rather as a legitimate resource for students with problems.

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